

Major incident policy re-audit

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INTRODUCTION

- A major incident is defined as a significant event, which demands a response beyond the routine, resulting from uncontrolled developments in the course of the operation of any establishment or transient work activity.
- The event may cause, or have the potential to cause, either: multiple serious injuries, cases of ill health (immediate or delayed), loss of life, serious disruption and extensive damage to property, inside or outside the establishment.

OBJECTIVES/AIMS

Acute hospitals nominated to respond to a major incident must:

- Have a major incident plan that considers all foreseeable causes of a major incident and all aspects of the hospital response.
- Ensure that staff are trained and equipped for their roles in a major incident.

The aim of this audit was to verify that all staff in the anaesthetic department were familiar with major incident procedures at Basingstoke Hospital.

METHODOLOGY

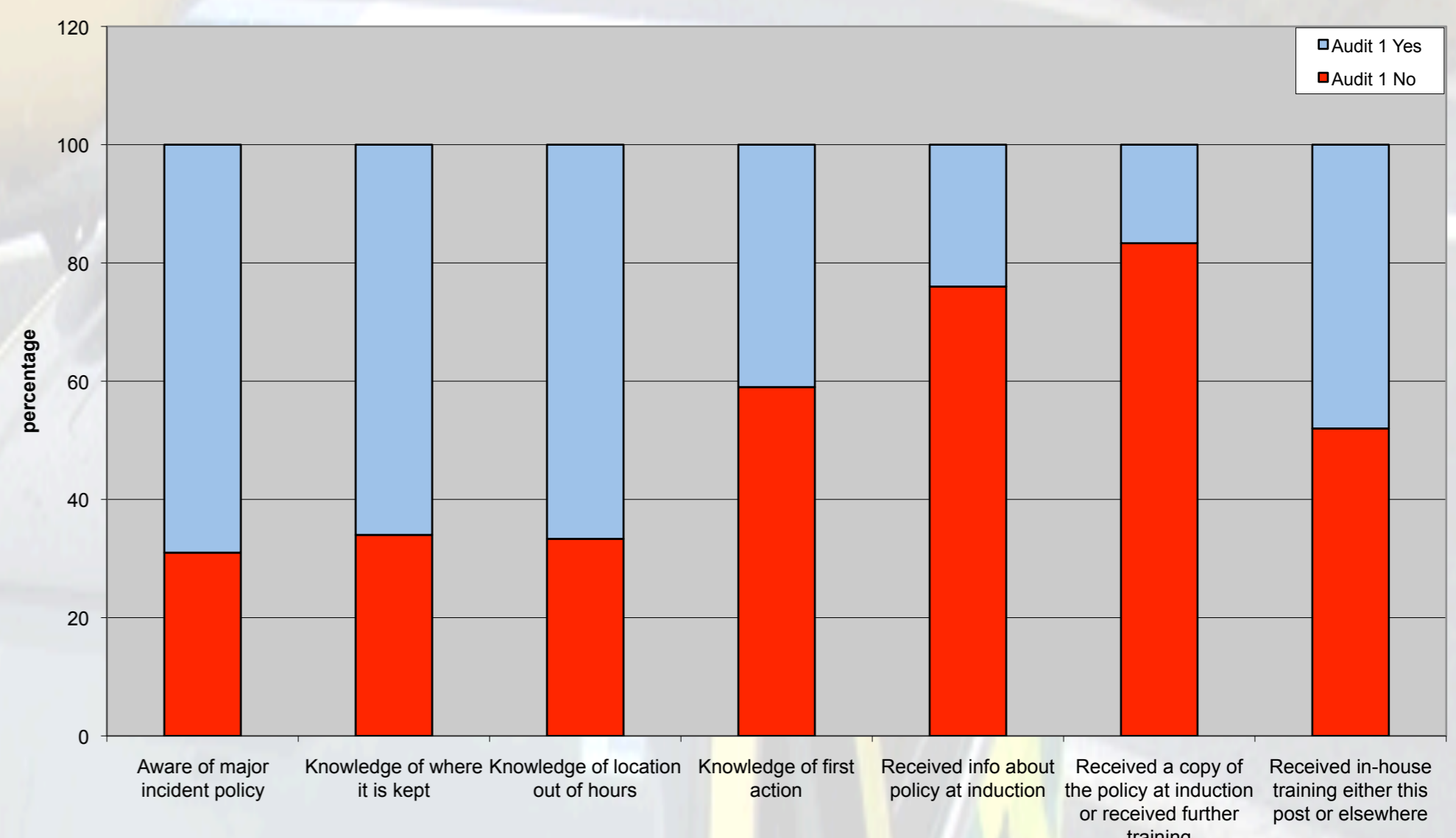
- An audit questionnaire was formulated which included the following questions:
 - Knowledge of a major incident policy within department
 - Knowledge of where it is kept
 - Knowledge of how to obtain it out of hours
 - Information received about the policy at trust induction
 - In-house training received on handling major incidents
- This was distributed and completed by 29 anaesthetists of all grades within the department.
- The data was collected, analyzed and compared with the standards set by the Royal College of Anaesthetists.

RESULTS

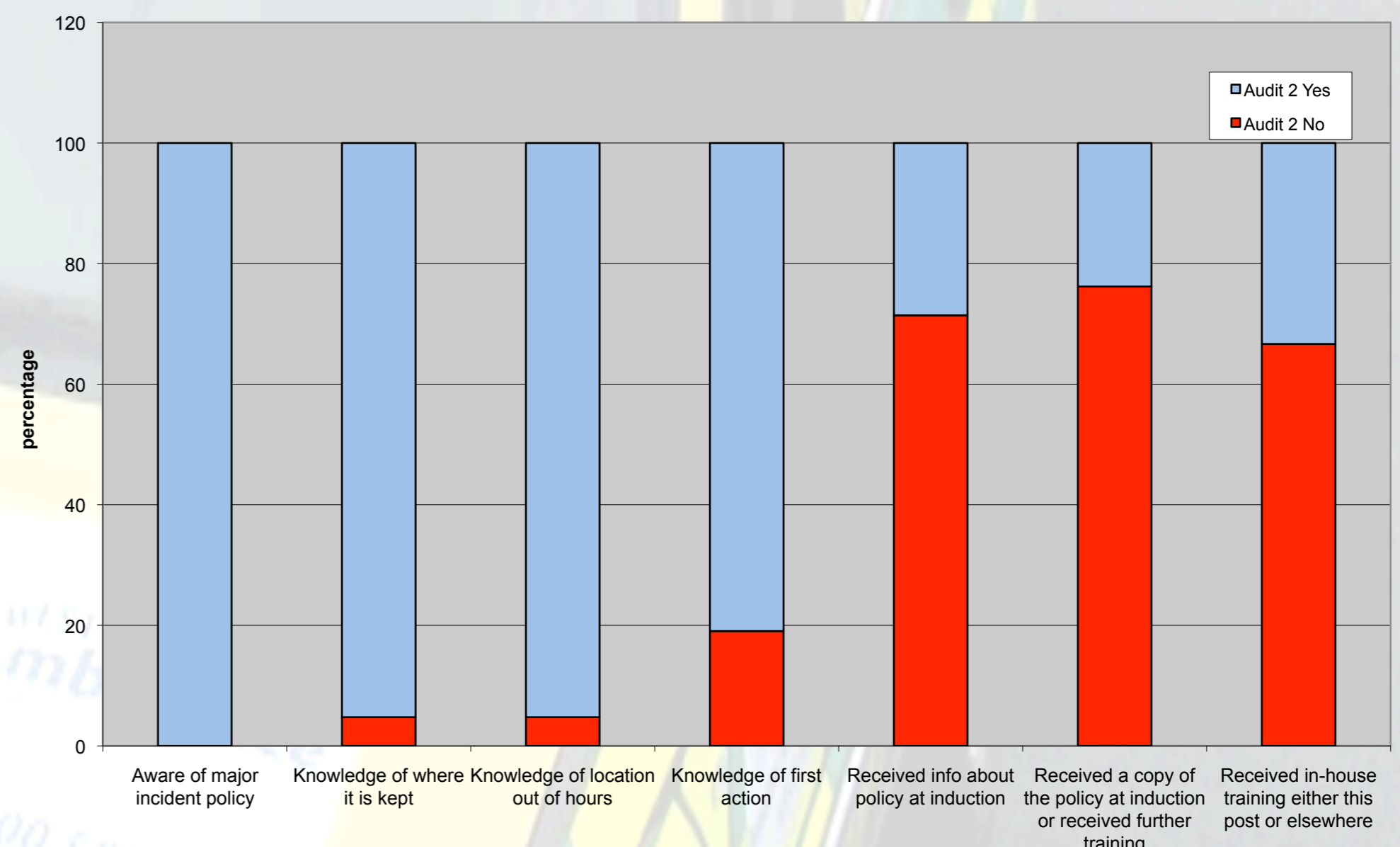
STRATEGY FOR CHANGE

- Presentation of audit and discussion at the departmental meeting.
- Copies of the major incident policy distributed to staff.
- Copies of the audit were sent to trust induction organizers.
- A re-audit was then performed.

Initial audit



Re-audit



CONCLUSIONS

- Knowledge of the major incident policy, where it is kept and first action in the event of declaration of a major incident were significantly improved post-intervention.
- However, most of the department have not received information at trust induction or have not received training in handling major incidents.

ACTION PLAN

- Audit to be extended to all members of staff in the anaesthetic department, intensive care and other departments within the hospital.
- Measures taken to ensure that the policy is distributed to all members of the department at induction.
- Plans in place to organize a major incident course at North Hampshire and Basingstoke NHS Foundation Trust.

References

- Raising the standard: A compendium of audit recipes, Royal College of Anaesthetists
- Department of Health. NHS emergency planning guidance 2005. *DH, London 2005*
- Health and Safety Executive

| Proposed standards | Audit |
|--|--|
| 100% of staff should know where the written major incident policy is kept and how to obtain it out of hours | 69% know where it is kept 66% know how to obtain it out of hours |
| 100% of staff (including consultants, trainees and administrative staff) should know what their first actions would be in the event of a major incident alert or a major incident. | 41% know what their first action would be |
| 100% of staff in post less than a year should have received information about the policy at their induction. | 24% received information at trust induction |
| 100 % of staff in post more than a year should have received training or information about the policy within the last year | 48% received training or information about the policy within the last year |